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ABSTRACT

This synopsis of the outcome literature on marital and family treatment (MFT) drew three conclusions. First, intervening at the marital/family level with nonalcoholic family members can motivate an initial commitment to change in the alcoholic who is unwilling to seek help. Second, MFT alone, or with individual alcoholism treatment, produces better marital and/or drinking outcomes during the 6 months following treatment entry than methods that don't involve the spouse or other family members. Third, studies of long-term maintenance suggest that behavioral marital therapy (BMT) with both an alcohol and relationship focus may reduce marital and/or drinking deterioration better than individual methods during long-term recovery. Recommendations for when, and at what level to intervene include the following: (1) intervene only at the individual level when the alcoholic refuses consent to contact family members or the family refuses involvement; (2) include adult family members who live with the alcoholic in the assessment process for all who consent; (3) intervene with family members when they seek and the alcoholic refuses help if both alcoholic and family members are free of serious drug abuse and major psychopathology; and (4) do not reserve MFT for alcoholics with serious relationship problems or for cases in which marital/family factors trigger or maintain the drinking. (LLL)

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Marital and Family Therapy: Implications of Research for Alcoholism Treatment*

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ABSTRACT

This synopsis of the outcome literature on marital and family treatment (MFT) drew three conclusions. First, intervening at the marital/family level with nonalcoholic family members can motivate an initial commitment to change in the alcoholic who is unwilling to seek help. Second, MFT alone, or with individual alcoholism treatment, produces better marital and/or drinking outcomes during the 6 months following treatment entry than methods that don't involve the spouse or other family members. The most promising MFT approach is behavioral marital therapy (BMT) that combines a focus on the drinking with work on other marital relationship issues via direct instigation of positive couple/family activities and teaching of communication and conflict resolution skills. Two BMT alcohol-focused methods have been used: a behavioral contract between alcoholic and spouse to maintain disulfiram ingestion; and "Alcohol-Focused Spouse Involvement" which rearranges reinforcement contingencies to decrease family behaviors that trigger or enable drinking and to increase positive reinforcement for sobriety. Third, studies of long-term maintenance suggest that BMT with both an alcohol and relationship focus may reduce marital and/or drinking deterioration better than individual methods during long-term recovery. The following recommendations were made for when to intervene at the level of the individual alcoholic only, at the marital/family level, or at both the individual and marital/family levels: (1) Intervene only at the individual level when the alcoholic refuses consent to contact family members or the family refuses involvement. (2) Include adult family members who live with the alcoholic in the assessment process for all who consent (3) Intervene with family members when they seek and the alcoholic refuses help if both alcoholic and family members are free of serious drug abuse and major psychopathology. Exclude domestic violence cases or teach family how to reduce risk of violence. (4) Use MFT alone or with individual treatment for when the alcoholic is

at least high school educated and employed, the alcoholic and spouse are living together and free of drug abuse and major psychopathology, the spouse is not alcoholic, and the level of violence does not risk serious injury or death. (5) Alcohol-focused MFT to support sobriety requires a moderately stable, cooperative family member in frequent, preferably daily contact and living with the alcoholic. If these conditions are not met, then individual work on sobriety facilitation is needed in addition to MFT on relationship problems. (6) Do not reserve MFT for alcoholics with serious relationship problems or for cases in which marital/family factors trigger or maintain the drinking.

In 1974 the National Institute on Alcohol Abuse and Alcoholism (NIAAA) called marital and family treatment (MFT) approaches "one of the most outstanding current advances in the area of psychotherapy of alcoholism" (Keller, 1974, p. 116). Then the enthusiasm came from numerous uncontrolled reports of MFT's benefits and from several other converging lines of evidence. Many alcoholics have extensive marital and family problems (e.g., O'Farrell & Birchler, 1987), and positive marital and family adjustment is associated with better alcoholism treatment outcomes at follow-up (e.g., Finney, Moos & Mewborn, 1980). Further, growing clinical and research evidence describes reciprocal relationships between marital-family interactions and abusive drinking. Problem drinking leads to marital and family discord, among the more serious of which are separation/divorce and child and spouse abuse. At the same time, marital and family problems may stimulate excessive drinking, and family interactions often help to maintain alcohol problems once they have developed (Davis, Berenson, Steinglass & Davis, 1974). Even when recovery from the alcohol problem has begun, marital and family conflicts may often precipitate renewed drinking by abstinent alcoholics (Maisto, O'Farrell, Connors, McKay & Pelcovits, 1988; Marlatt & Gordon, 1985). Finally, MFT can help not only the alcoholic but also the "other victims" of alcoholism since it has been estimated that each alcoholic affects at least four other persons with family members affected most frequently (National Institute of Alcohol Abuse and Alcoholism, 1981).

The enthusiasm in the field, the plausibility, and the political appeal of a method that promises help to a larger constituency than the alcoholics themselves all make MFT a topic of interest to clinicians, scientists and policy makers. This paper provides a synopsis of the current outcome literature on MFT with the goal of presenting practical recommendations for deciding when to intervene at the level of the individual alcoholic only, at the marital/family level, or at both the in-

dividual and marital/family levels. In reviewing the literature and formulating practical recommendations, the process of change for the alcoholic will be divided into three broadly defined stages of recovery (Prochaska & Diclemente, 1983): (a) initial commitment to change -- recognizing that a problem exists and deciding to do something about it, (b) the change itself -- stopping abusive drinking and stabilizing this change for three to six months, and (c) the long-term maintenance of change. Seven of the 13 studies reviewed, all of which had a comparison group and follow-up data, were not included in earlier reviews (Janzen, 1977; O'Farrell & Cutter, 1977; Steinglass, 1976, 1977) of the MFT literature.

Synopsis of the MFT and alcoholism literature

MFT to promote change in the alcoholic. A behavior therapy program for teaching the nonalcoholic family member (usually the wife) of a male alcoholic how to reduce physical abuse to herself, how to encourage the alcoholic's sobriety and seeking of professional treatment, and how to assist in that treatment resulted in more alcoholics entering treatment than did a more traditional program for family members which consisted of alcohol education, individually-oriented supportive counseling, and referral to Al-Anon (Sisson & Azrin, 1986). In addition, alcoholics with relatives in the reinforcement program showed significantly reduced alcohol use prior to entering treatment while the control group alcoholics did not. Thomas, Santa, Bronson and Oyserman (1987) conducted a pilot study on Unilateral Family Therapy (UFT), an intervention with the spouse to improve spouse coping, reduce drinking, and promote treatment entry for the alcohol abuser (Thomas & Santa, 1982). Results showed that 61 percent of the alcohol abusers with spouses who received UFT improved by decreased drinking and/or movement into treatment while none of the alcohol abusers with spouses in the no treatment group showed improvement.

Similar encouraging results were obtained in an earlier, less rigorous study (Cohen & Krause, 1971) which evaluated a Family Service Agency program using the disease model of alcoholism and techniques for treating the wives of alcoholics. Further, the Johnson Institute "intervention" procedure, which involves three to four educational and rehearsal sessions with family members prior to confronting the alcoholic about his or her drinking and strongly encouraging treatment entry (Thorne, 1983), is a widely known and used MFT method for which controlled outcome data are not available. Thus, two recent studies, as well as current clinical practice and earlier less controlled research, suggest that intervening at the marital/family level with nonalcoholic family members can motivate an initial commitment to change in the alcoholic who is unwilling to seek help. Replication of these results and evaluation of the widely used Johnson Institute intervention are needed.

MFT to produce and stabilize short-term drinking and relationship changes. More alcoholics whose wives chose to attend a therapy group, which focused on increasing wives' understanding of alcoholism and the role of the marital relationship in the husband's alcoholism, were abstinent or improved at 16 month follow-up than were alcoholics whose wives refused this offer (Smith, 1969). Self-selection rather than random assignment to conditions mars this study which provides only rather limited empirical support for separate and concurrent treatment for the alcoholic and spouse, a once popular method (Steinglass, 1976) that has been replaced by methods that involve the alcoholic and spouse together in treatment.

A behavioral contract to maintain Antabuse (disulfiram) in which a significant other, usually the spouse, observed and reinforced the ingestion of the medication produced much better abstinence rates among alcoholic outpatients at six-month follow-up than did a traditional, self-initiated disulfiram treatment (Azrin, Sisson, Meyers & Godley, 1982). A second study (Keane, Foy, Nunn & Rychtarik,

1984) did not find an advantage of a disulfiram contract over a prescription alone in outcomes for male alcoholics during the three months after being discharged from a 4-week behaviorally oriented inpatient alcoholism treatment program. Given the differing results of these two studies, the evidence that patients who stay on disulfiram have better treatment outcomes (Fuller, et al., 1986), and the good outcomes of programs that have included a disulfiram contract (e.g., Azrin, 1976; O'Farrell & Cutter, 1982; O'Farrell, Cutter & Floyd, 1985), further research is needed.

In 1970 multiple couples group therapy was called the "treatment of choice for married alcoholics" (Gallant, Rich, Bey & Terranova, 1970) on the basis of uncontrolled reports and a retrospective survey showing greater client satisfaction with this type of MFT than with individual treatment (Burton & Kaplan, 1968). Interestingly, this early enthusiasm for couples group treatment has been supported by later more controlled studies. More alcoholics who received an intensive residential marital couples group workshop in addition to an inpatient alcohol rehabilitation program were abstinent and participating in recreational activities together with their wives at six month follow-up than were alcoholics in a comparison group treated with the standard individual inpatient only (Corder, Corder & Laidlaw, 1972). More outpatient alcoholics treated with interactional couples group therapy, which targeted improved marital communication and problem-solving, were abstinent or improved at six months follow-up than were their counterparts assigned to a waiting list control group (Cadogan, 1973).

In the Counseling for Alcoholics' Marriages (CALM) Project (O'Farrell & Cutter, 1982; O'Farrell, et al., 1985), a recent well-controlled study, male alcoholics who had recently begun invididual outpatient alcoholism counseling that included a disulfiram prescription were randomly assigned to a no-marital-treatment control group, or to 10 weekly sessions of either a behavioral marital therapy

(BMT: disulfiram contract plus behavioral instigation of positive interactions and rehearsal of communication skills) or an interactional (largely verbal interaction and sharing of feelings without disulfiram contract) couples group. Marital adjustment results showed BMT couples: improved from pre to post on a variety of measures and remained significantly improved at two and six-month follow-ups; did better than control couples (who did not improve on any measures); and did better than interactional couples from pre to post but this BMT superiority was reduced to nonsignificant trends at follow-ups. On drinking adjustment, alcoholics in all three treatments showed significant improvements that were sustained at follow-ups and BMT subjects did better than interactional subjects at post and at two month follow-up. The investigators concluded that adding a BMT couples group to outpatient alcoholism counseling showed clear advantages for the alcoholics' marital relationships but no additional gains in drinking adjustment. The less positive results for the interactional couples group suggested that just talking about relationship problems without making specific changes may lead to conflict and drinking and that the disulfiram contract may have protected the BMT couples while they learned new skills to confront their problems without alcohol.

An earlier study (Hedberg & Campbell, 1974) also provided support for behavioral family counseling (BFC) in communication skills, learning principles, and behavioral contracts. When compared with three other individual behavior therapy methods at six-month follow-up, BFC was the most effective treatment regardless of whether the patients' goal was abstinence or controlled drinking; and BFC was particularly effective for patients with abstinence goals (Hedberg & Campbell, 1974).

McCrady and colleagues conducted two studies comparing differing MFT methods. The first study (McCrady, Paolino, Longabaugh & Rossi, 1979) randomly assigned subjects to (a) individual involvement in which only the alcoholic attended group

therapy; (b) couples involvement consisting of an outpatient interactional couples therapy group in addition to concurrent individual treatment groups for each spouse; or (c) joint hospital admission for both partners followed by both the couples group and concurrent individual therapy groups. Six-month follow-up findings showed decreases in marital problems for all groups and decreases in alcohol intake for both the couples involvement and joint admission treatment groups but not for the individual treatment group. The Program for Alcoholic Couples Treatment (PACT) project, as the second McCrady study (McCrady, et al., 1986) was called, compared three types of spouse involvement: (a) minimal spouse involvement (MSI) in which the spouse simply observed the alcoholic's individual therapy; (b) alcohol-focused spouse involvement (AFSI) which included teaching the spouse specific skills to deal with alcohol-related situations plus the MSI interventions; (c) alcohol behavioral marital therapy (ABMT) in which all skills taught in the MSI and AFSI conditions were included as well as BMT. Results at 6 month follow-up indicated that all subjects had decreased drinking and reported increased life satisfaction and suggested ABMT led to better treatment outcomes than the other spouse-involved therapies. Specifically, ABMT couples: maintained their marital satisfaction after treatment better and tended to have more stable marriages than the other two groups; and were more compliant with homework assignments, decreased the alcoholics' number of drinking days during treatment, and their post-treatment drinking increased more slowly than AFSI couples.

In summary, evidence is accumulating that MFT helps stabilize marital and family relationships and supports improvements in alcoholics' drinking during the 6 month period following treatment entry for alcoholism. MFT alone or in addition to individual alcoholism treatment produces better marital and/or drinking outcomes during this time period than methods that don't involve the spouse or other family members. Support is found for MFT delivered in multiple couple groups and one

couple at a time, but not for joint hospitalization or concurrent spouse sessions. The most promising MFT approach combines both a focus on the drinking and drinking related communications plus work on more general marital relationship issues (O'Farrell & Cutter, 1982; O'Farrell, et al., 1985; McCrady, et al., 1986). Two alcohol-focused methods have been used in recent studies: (a) a behavioral contract between alcoholic and spouse to maintain disulfiram ingestion (Arzin, et al., 1982; O'Farrell & Cutter, 1982; O'Farrell, et al., 1985); and (b) "Alcohol-Focused Spouse Involvement" (AFSI) which consists of rearranging reinforcement contingencies in the family to decrease family member behaviors that trigger or enable drinking and to increase positive reinforcement for sobriety (McCrady, et al., 1986). Although disulfiram contracts may produce more stable abstinence than AFSI in the initial treatment phase, AFSI seems to enhance longer term outcomes (McCrady, et al., 1986). Tentative support is found for superior results with more structured, directive, behaviorally oriented MFT methods that directly instigate positive couple and family activities and teach communication skills as compared to other MFT methods (O'Farrell & Cutter, 1982; O'Farrell, et al., 1985).

MFT and long-term maintenance. Research is just starting to focus on the effects of MFT during long term recovery. Data available come from long-term follow-up outcomes of recent studies, the intermediate term outcomes of which have just been reviewed. Four-year follow-up data from the joint hospitalization and couples therapy study (McCrady, Moreau, Paolino & Longabaugh, 1982) showed a commonly observed pattern of decay in outcomes over time and no differences among the different treatment groups on either marital or drinking adjustment. Results from the CALM and PACT studies, which have been presented but not published yet (O'Farrell & Cutter, 1982; Stout, McCrady, Longabaugh, Noel & Beattie, 1987), suggest that BMT with both an alcohol and relationship focus may reduce marital and/or drinking deterioration during long-term recovery. Considerably more

research is needed to substantiate this conclusion. Finally, O'Farrell and colleagues are currently conducting a second Project CALM study to evaluate whether couples who receive BMT relapse prevention sessions in the year after a short-term BMT couples group do better at long-term follow-up than do couples not receiving the additional relapse prevention. The study tests the prediction that only some couples will derive greater benefits from the additional relapse prevention sessions, namely couples with more severe alcohol and marital problems and a pattern of marital conflict often preceding drinking.

Recommendations

Clinical practice recommendations. An important question for clinicians and program directors concerns what criteria can be used for determining when to intervene at the marital/family level only, the individual level only, or both the individual and marital/family level. Unfortunately, studies examining predictors of differential response to MFT versus individual treatment are not yet available so a firm empirical basis for answering the question is lacking. Therefore, clinical experience and extrapolation from available literature were used to make the following recommendations for current clinical practice.

1. Intervene only at the individual level when the alcoholic has sought help and refuses consent to contact family members unless there are compelling reasons to act otherwise (e.g., alcoholic imminently dangerous to self or others).

2. Include the spouse or other adult family members who live with the alcoholic in the assessment process and in the feedback from the assessment for all adult alcoholics who seek help and consent.

3. Intervene at the marital/family level with family members when they seek help, and the alcoholic refuses direct invitation by the therapist to come in for a session, to improve family member coping and to attempt to initiate change and treatment seeking by the alcoholic. Criteria that recent studies (Sisson & Azrin,

1986; Thomas & Santa, 1982; Thomas, et al., 1987) have used to select appropriate cases for this type of intervention include absence of drug abuse, major psychopathology, or immediate plans for marital dissolution for either spouse. Domestic violence cases need to be excluded (Thomas & Santa, 1982; Thomas, et al., 1987) or the spouse must be taught how to reduce the likelihood of violence as Sisson and Azrin (1986) did.

4. Include the spouse in sessions with the alcoholic either as the primary treatment or in combination with individual therapy for the alcoholic when the alcoholic has sought help and the spouse is willing. Studies of factors that predict alcoholics' acceptance and completion of MFT (Noel, McCrady, Stout & Nelson, 1987; O'Farrell, Kleinke & Cutter, 1986; Zweben, Pearlman & Li, 1983) and criteria used to exclude subjects from MFT studies in the literature suggest that clients most likely to benefit from MFT have the following characteristics: (a) a high school education or better; (b) employed full-time if able and desirous of working; (c) live together or, if separated, are willing to reconcile for the duration of the therapy; (d) older; (e) have more serious alcohol problems of longer duration; (f) enter therapy after a crisis, especially one that threatens the stability of the marriage; (g) spouse and other family members not alcoholic; (h) alcoholic, spouse, and other family members without serious psychopathology or drug abuse; and (i) absence of family violence that has caused serious injury or is potentially life-threatening. Further, evidence that the alcoholic is motivated to change and to take an active role in a psychologically oriented treatment approach also suggests potential for benefitting from MFT. Such evidence includes the alcoholic personally initiating contact with the treatment program and a history of successful participation in other outpatient counseling or self-help programs (as opposed to only detoxification admissions for relief of physical distress due to heavy drinking without further active ongoing treatment participation). Clinical

experience suggests that compliance with the initial month of outpatient treatment including abstinence, keeping scheduled appointments, and completing any required assignments are process measures that seem to predict likely benefit. Clients do not have to fit all of these criteria for therapists to use MFT. Rather the marital and family methods have to be adapted for some of the more difficult cases generally by going slower, individualizing the approach to a greater degree, and dealing with more varied and more frequent obstacles and resistances. Strategies for dealing with some of the more difficult cases (e.g. the separated alcoholic, the family with more than one alcohol-abusing member) have been presented elsewhere (O'Farrell, 1986a; O'Farrell, 1986b).

5. The question of when to use MFT alone versus in combination with individual approaches is more difficult to answer since there are no data on the subject and studies have found good outcomes with both approaches. MFT to directly support sobriety using alcohol-focused methods requires a moderately stable, cooperative family member in frequent, preferably daily contact and living with the alcoholic. If these conditions are not met, then individual work on sobriety facilitation is needed in addition to MFT which can be used in such cases to repair damaged relationships and resolve conflicts and problems. Other cases which require individual treatment in addition to MFT are those that require detoxification, have a strong preference for or are already involved in an individual program when MFT starts, or have not responded well to MFT alone, especially when the poor response seems due to nonmarital factors.

6. Do not reserve MFT for alcoholics who have serious marital and family problems secondary to, preceding, or coexisting with the alcohol problem or for cases in which clear evidence indicates an important role for marital/family factors in triggering or maintaining the abusive drinking. Clinical experience suggests that couples with low to moderate levels of marital/family problems may be

better able to work together to support the alcoholic's sobriety and to enrich their marital/family relationships which have been strained by alcoholism-related stressors. A recent study found that BMT plus individual counseling improved positive communication more than individual counseling alone only for those couples who displayed at least moderate levels of positive communication at the start of therapy (O'Farrell, et al., 1985). Further, even when maintaining conditions for the drinking are not directly or strongly related to marital/family factors, MFT may strengthen the alcoholic's ability to refrain from drinking while learning to deal with nonmarital factors and may help generate and support alternative behaviors.

7. Therapists who use MFT extensively should have specific training in MFT methods the literature suggests are likely to be effective. In addition, clinical experience suggests the following therapist attributes and behaviors are important for successful MFT. (a) From the outset, the therapist must structure treatment so that control of the alcohol abuse is given priority before attempting to help the couple or family with other problems. (b) Therapists need to be able to tolerate and deal effectively with strong anger in early sessions and at later times of crisis since failure to do so often leads to a poor outcome (Gurman & Kniskern, 1978). (c) Therapists need to structure and take control of treatment sessions, especially during the early assessment and therapy phase and at later times of crisis. Many therapists' errors involve difficulty establishing and maintaining control of the sessions and responding to the myriad of resistances and noncompliances presented by couples and families. (d) Finally, therapists need to take a long-term view of the course of change of an alcoholism problem so they can encounter relapse without becoming overly discouraged or engaging in blaming and recriminations with the alcoholic and family. (e) The therapist also should maintain contact with the family after the problems apparently have stabilized.

Leaving such contacts to the family usually means no follow-up contacts occur until a major crisis occurs.

MFT training and research recommendations. Available knowledge about MFT methods that are supported by research findings needs to be disseminated to and used by the practitioner community. A few articles in practitioner journals (e.g., O'Farrell & Bayog, 1986; O'Farrell & Cutter, 1984) and book chapters (e.g., O'Farrell, 1986a; O'Farrell, 1986b; McCrady, 1982) have appeared and treatment manuals were written for recent studies (e.g., Sisson & Azrin, 1986; O'Farrell, et al., 1985; McCrady, et al., 1986) but not disseminated. Books, videotapes, and workshops are rare or nonexistent. Contrast this with the fact that a considerable number of books and workshops, and some materials for use with clients, are readily available that provide information about MFT methods for which empirical support is not available. Funding and encouragement needs to be provided for developing high quality therapist and client materials, programs to train practitioners, and other vehicles to disseminate and increase the use of MFT methods which have empirical support for their effectiveness.

Future research is needed to provide larger scale, probably multi-site replications of promising MFT methods. Unilateral Family Therapy (Thomas & Santa, 1982; Thomas, et al., 1987), Sisson and Azrin's program (1986), and the Johnson Institute intervention (Thorne, 1983; by virtue of its widespread use) are all methods useful to initiate change in the alcoholic that deserve further research. If only one method was chosen for replication the Sisson and Azrin method currently has the strongest empirical support. Such a replication should include a requirement to develop procedures and methods to assess the alcohol abuser's drinking problem severity accurately through family members' reports and safeguards to prevent coercing the alcohol abuser into overly restrictive treatment goals and programs. Disulfiram contracts and Alcohol-Focused Spouse Involvement (AFSI) are

two alcohol-focused methods that, along with behavioral marital therapy (BMT) to instigate positive activities and teach communication and conflict resolution skills, are MFT methods to stabilize change that deserve replication and further study. Longterm outcome studies, especially those that study the role of MFT in relapse prevention and long-term recovery, are badly needed. All of these recommended studies should not be funded unless they attempt to identify patient characteristics that predict differential response to MFT versus other methods. In this regard, investigators could relax subject selection criteria to study the generality of MFT effects.

MFT is a treatment method and a research area in alcoholism that has great potential for reducing human suffering and advancing knowledge about alcoholism. Barriers to progress in this area need to be reduced and a coherent plan of action for research of the next decade needs to be developed. The increasing privatization of alcoholism treatment in the U.S. means that the majority of alcoholics are treated in private for profit non-university affiliated settings where research is not a priority. Recent MFT studies have been conducted by investigators in university or medical schools who have been hampered by difficulty getting enough suitable subjects. Further, when a study is completed, the grant-funded therapists and support personnel (and often the investigator) move on. We need to form partnerships between MFT researchers, who can provide scientific expertise and access to research funding, and treatment settings that have an ample supply of alcoholics with intact families and a relatively stable staff of therapists. Such a treatment setting also could act as a local resource for therapists trained in specialized MFT methods (e.g., sex therapy, parent-adolescent problems) often needed by alcoholics' families but seldom available in alcoholism treatment settings or elsewhere from professionals knowledgeable about alcoholism.

Planning the research of the next decade could be aided by a conference combining MFT researchers and innovative practitioners to share ideas and provide recommendations for research. The paucity of available material on some important topics suggest the need for new research that goes beyond the current literature. A pressing need exists for the development of brief, practical family assessment methods that can be implemented when the alcoholic seeks treatment to determine when individualized assistance is needed for other members of the family, especially children. In addition, there is clearly a need to develop and scientifically evaluate MFT specifically for adult female alcoholics, adolescent alcohol abusers, the couple/family with more than one actively alcoholic member, and for use in early identification and early intervention programs. Finally, the role of marital/family interventions for the prevention of alcohol problems should be carefully explored. For example, specific consideration should be given to family education to prevent the fetal alcohol syndrome, the role of the family in educating children in responsible drinking practices, and marital/family education of high-risk groups (e.g., children of alcoholics) prior to or early in marriage.

REFERENCES

Azrin, N.H. (1976). Improvements in the community-reinforcement approach to alcoholism. Behavior Research Therapy, 14, 339-348.

Azrin, N.H., Sisson, R.W., Meyers, R., & Godley, M. (1982). Alcoholism treatment by Disulfiram and community reinforcement therapy. Journal of Behavior Therapy and Experimental Psychiatry, 13, 105-112.

Burton, G., & Kaplan, H.M. (1968). Group counseling in conflicted marriages where alcoholism is present: Client's evaluation of effectiveness. Journal of Marriage and the Family, 30, 74-79.

Cadogan, D.A. (1973). Marital group therapy in the treatment of alcoholism. Quarterly Journal of Studies on Alcohol, 34, 1187-1194.

Cohen, D.C., & Krause, M.S. (1971). Casework with the wives of alcoholics. New York: Family Service Assoc. of America.

Corder, B.F., Corder, R.F., & Laidlaw, N.D. (1972). An intensive treatment program for alcoholics and their wives. Quarterly Journal of Studies on Alcohol, 33, 1144-1146.

Davis, D.I., Berenson, D., Steinglass, P., & Davis, S. (1974). The adaptive consequences of drinking. Psychiatry, 37, 209-215.

Finney, J.W., Moos, R.H., & Mewborn, C.R. (1980). Posttreatment experiences and treatment outcome of alcoholic patients six months and two years after hospitalization. Journal of Consulting and Clinical Psychology, 48, 17-29.

Fuller, R.K., Branchey, L., Brightwell, D.R., Derman, R.M., Emrick, C.D., Iber, F.L., James, K.E., Lacoursiere, R.B., Lee, K.L., Lowenstam, I., Maany, I., Neiderhister, D., Nocks, J.J., & Shaw, S. (1986). Disulfiram treatment of alcoholism. Journal of the American Medical Association, 256, 1449-1455.

Gallant, D.M., Rich, A., Bey, E., & Terranova, L. (1970). Group psychotherapy with

married couples: A successful technique in New Orleans Alcoholism Clinic patients. Journal of the Louisiana State Medical Society, 122, 41-44.

Gurman, A.S., & Kniskern, D.P. (1978). Deterioration in marital and family therapy: Empirical, clinical and conceptual issues. Family Process, 17, 3-20.

Hedberg, A.G., & Campbell, L. (1974). A comparison of four behavioral treatments of alcoholism. Journal of Behavior Therapy and Experimental Psychiatry, 5, 251-256.

Janzen, C. (1977). Families in the treatment of alcoholism. Journal of Studies on Alcohol, 38, 114-130.

Keane, T.M., Foy, D.W., Nunn, B., & Rychtarik, R.G. (1984). Spouse contracting to increase Antabuse compliance in alcoholic veterans. Journal of Clinical Psychology, 40, 340-344.

Keller, M. (Ed.). (1974). Trends in treatment of alcoholism. In Second special report to the U.S. Congress on alcohol and health pp. 145-167. Washington, DC: Department of Health, Education, and Welfare.

Maisto, S.A., O'Farrell, T.J., Connors, G.J., McKay, J., & Pelcovits, M.A. (1988). Alcoholics' attributions of factors affecting their relapse to drinking and reasons for terminating relapse events. Addictive Behaviors, 13, 79-82.

McCrady, B.S. (1982). Conjoint behavioral treatment of an alcoholic and his spouse. In Hay, W.M. & P.E. Nathan (Eds.), Clinical case studies in the behavioral treatment of alcoholism. New York: Plenum Press. pp. 127-156.

McCrady, B.S., Moreau, J., Paolino, T.J., Jr., & Longabaugh, R. (1982). Joint hospitalization and couples therapy for alcoholism: A four-year follow-up. Journal of Studies on Alcohol, 43, 1244-1250.

McCrady, B.S., Noel, N.E., Abrams, D.B., Stout, R.L., Nelson, H.F., & Hay, W.M. (1986). Comparative effectiveness of three types of spouse involvement in out-

patient behavioral alcoholism treatment. Journal of Studies on Alcohol, 47, 459-467.

McCrady, B.S., Paolino, T.J., Jr., Longabough, R., & Rossi, J. (1979). Effects of joint hospital admission and couples treatment for hospitalized alcoholics: A pilot study. Addictive Behaviors, 4, 155-165.

Marlatt, G.A., & Gordon, J. (1985). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. New York: Guilford.

National Institute on Alcohol Abuse and Alcoholism. (1981). Someone Close Drinks Too Much (DHHS Publication No. ADM 81-123). Washington, DC: U.S. Government Printing Office.

Noel, N.E., McCrady, B.S., Stout, R.L., & Nelson, H.F. (1987). Predictors of attrition from an outpatient alcoholism treatment program for alcoholic couples. Journal of Studies on Alcohol, 48, 229-235.

O'Farrell, T.J. (1986a). Marital and family therapy for alcohol problems. In W.M. Cox, (Ed.), Treatment and prevention of alcohol problems: A resource manual. New York: Academic Press. (pp. 205-233)

O'Farrell, T.J. (1986b). Marital therapy in the treatment of alcoholism. In N.S. Jacobson & A.S. Gurman, (Eds.), Clinical handbook of marital therapy. New York: Guilford Press. (pp. 513-535)

O'Farrell, T.J., & Bayog, R.D. (1986). Antabuse contracts for married alcoholics and their spouses: A method to insure Antabuse taking and decrease conflict about alcohol. Journal of Substance Abuse Treatment, 3, 1-8.

O'Farrell, T.J., & Birchler, G.R. (1987). Marital relationships of alcoholic, conflicted, and nonconflicted couples. Journal of Marital and Family Therapy, 13, 259-274.

O'Farrell, T.J.,& Cutter, H.S.G. (1984). Behavioral marital therapy couples groups

for male alcoholics and their wives. Journal of Substance Abuse Treatment, 1, 191-204.

O'Farrell, T.J., & Cutter, H.S.G. (1977). Behavioral marital therapy for alcoholics and wives: Review of literature and a proposed research program. Paper presented at NATO Conference on Experimental and Behavioral Approaches to Alcoholism, Bergen, Norway. (ERIC Document Reproduction Service No. ED 155 531.)

O'Farrell, T.J., & Cutter, H.S.G. (November, 1982). Effect of adding a behavioral or an interactional couples group to individual outpatient alcoholism counseling. In T.J. O'Farrell, Chair, Spouse-involved treatment for alcohol abuse. Symposium conducted at the Sixteenth Annual Convention of the Association for the Advancement of Behavior Therapy, Los Angeles.

O'Farrell, T.J., Cutter, H.S.G., & Floyd, F.J. (1985). Evaluating behavioral marital therapy for male alcoholics: Effects on marital adjustment and communication from before to after therapy. Behavior Therapy, 16, 147-167.

O'Farrell, T.J., Kleinke, C., & Cutter, H.S.G. (1986). Differences between alcoholic couples accepting and rejecting an offer of outpatient marital therapy. American Journal of Drug and Alcohol Abuse, 12, 301-310.

Prochaska, J.O., & DiClemente, C.C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. Journal of Consulting and Clinical Psychology, 51, 390-395.

Sisson, R.W., & Azrin, N.H. (1986). Family-member involvement to initiate and promote treatment of problem drinkers. Journal of Behavior Therapy and Experimental Psychiatry, 17, 15-21.

Smith, C.G. (1969). Alcoholics: Their treatment and their wives. British Journal of Psychiatry, 115, 1039-1042.

Steinglass, P. (1976). Experimenting with family treatment approaches to alcoholism, 1950-1975: A review. Family Process, 15, 97-123.

Steinglass, P. (1977). Family therapy in alcoholism. In B. Kissin & H. Begleiter, (Eds.), The Biology of Alcoholism (Vol. 5). New York: Plenum, 259-299.

Stout, R.L., McCrady, B.S., Longabaugh, R., Noel, N.E., & Beattie, M.C. (1987). Marital therapy enhances the long-term effectiveness of alcohol treatment. Alcoholism: Clinical and Experimental Research, 11, 213 (Abstract).

Thomas, E.J., Santa, C.A. 1982. Unilateral family therapy for alcohol abuse: A working conception. American Journal of Family Therapy, 10, 49-60.

Thomas, E.J., Santa, C.A., Bronson, D., & Oyserman, D. (1987). Unilateral family therapy with spouses of alcoholics. Journal of Social Service Research, 10, 145-163.

Thorne, D.R. (1983). Techniques for use in intervention. Journal of Alcohol and Drug Education, 28, 46-50.

Zweben, A., Pearlman, S., & Li, S. (1983). Reducing attrition from conjoint therapy with alcoholic couples. Drug and Alcohol Dependence, 11, 321-331.